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ABSTRACT

Several theorists have advocated marital therapy in treatment programs for alcoholics. Given the promise of marital therapy for alcoholics, it is important to develop successful techniques for recruitment. One approach toward improving recruitment is to identify the characteristics of couples who are likely to accept or reject marital therapy. Following an extensive evaluation in which husbands and wives separately completed questionnaires about their marriage and an interview about the alcoholic's drinking, 35 couples with alcoholic husbands decided to participate in couples therapy (acceptors) and 28 couples did not (rejectors). Data from the evaluation were used to examine ten demographic variables, the severity of the husband's drinking and the couple's marital problems, previous help-seeking behaviors, and each spouse's motivation to improve the marriage. A stepwise multiple discriminant analysis was used to compare scores of acceptors and rejectors. A significant discriminant function indicated that acceptors were characterized by husbands with more education, better marital adjustment, full-time employment, and a larger number of alcohol-related arrests. Acceptors also had sought more outpatient help in the past year. Rejectors were characterized by wives with better marital adjustment, greater living distance from the clinic, and husbands with more alcohol-related hospitalizations. Rejector husbands also tended to be older. These findings have implications for planning efforts to attract alcoholics likely to accept marital therapy and for identifying and dealing with potential rejectors of marital therapy among patients in alcoholism treatment programs. (NRB)

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Differences Between Alcoholic Couples Accepting and Rejecting an Offer of Outpatient Marital Therapy

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Differences Between Alcoholic Couples

Accepting and Rejecting an Offer of Outpatient Marital Therapy

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Abstract

Following an extensive initial evaluation, 35 couples with alcoholic husbands decided to participate in couples therapy (acceptors) and 28 couples did not (rejectors). A significant discriminant function indicated that acceptors were characterized by husbands with more education, better marital adjustment, full-time employment, and larger number of alcohol-related arrests. Acceptors also had sought more outpatient help in the past year. Rejectors were characterized by wives with better marital adjustment, greater living distance from clinic, and husbands with more alcohol-related hospitalizations. Rejector husbands also tended to be older. Practical implications for recruiting alcoholics and spouses into marital therapy are discussed.

Differences Between Alcoholic Couples Accepting and Rejecting an Offer of Outpatient Marital Therapy

Introduction

Marital therapy is being used increasingly to alleviate the suffering of couples troubled by relationship conflict and alcoholic drinking. In recognition of this trend, the Second Special Report to the U.S. Congress on Alcohol and Health (Keller, 1974) called marital and family treatment approaches "the most notable current advance in the area of psychotherapy of alcoholism." Recent reviews from diverse theoretical standpoints (O'Farrell & Cutter, 1977; Steinglass, 1976) have advocated marital therapy as a component of treatment programs for alcoholics, and the number of alcoholism treatment programs that include a marital therapy component is growing.

Given the promise of marital therapy for alcoholics, it is important to develop successful techniques for recruitment. The scope of the recruitment problem can be appreciated by the fact that only half of the alcoholic couples who were offered marital therapy in recent studies agreed to participate (McCrady et al., 1979; O'Farrell et al., 1985).

One approach toward improving recruitment is to identify the characteristics of couples who are likely to accept or reject the marital therapy. Knowledge of these characteristics would allow alcoholism treatment programs that wish to offer marital therapy (a) to target their recruitment efforts to attract clients likely to accept marital therapy and (b) to identify potential rejectors among their existing patient populations who may need special efforts to motivate them to participate in such treatment. Since alcoholism is a major health problem in the U.S., this is a worthy challenge. The present study used multivariate statistics (see Kaplan & Litrownik, 1977) to identify differences between couples with alcoholic husbands who either accepted or rejected marital therapy.

Methods

Subjects

Throughout the intake phase of a study evaluating the use of couples group therapy with male alcoholics and their wives (O'Farrell et al, in press), each married alcoholic who entered the inpatient and outpatient alcoholism programs at the Veterans Administration Medical Center in Brockton, Massachusetts was contacted during the first month of treatment to recruit him and his wife to participate in the study. The Counseling for Alcoholic Marriages (CALM) Project (as this study was called) was described to the alcoholics and their wives as an opportunity for couples to overcome the damage done to a marriage by alcoholism, and a rationale for the use of couples therapy when the alcoholic stops drinking was presented. Couples who expressed interest in the project and met the criteria for participation (see O'Farrell et al., 1985) signed information sheets as part of informed consent procedures. Then these couples completed an extensive initial evaluation in which husband and wife separately completed questionnaires about their marriage and an interview about the alcoholic's drinking. In a second session, the results of the evaluation and the potential benefits of participation in the project were presented to the couple. After the feedback session, the couple decided whether or not to participate further. Subjects for the present study were the 63 couples who completed an initial evaluation. Table 1 presents descriptive characteristics for the sample studied. Thirty-five couples chose to continue after the initial evaluation and to participate in the couples therapy research program (acceptors) and 28 couples did not (rejectors).

Insert Table 1 about here.

Measures

Three groups of measures were assumed to have relevance to the decision to accept or reject outpatient marital therapy: (a) demographics chosen because of their importance in related studies (Baekeland & Lundwall, 1975; Hahn & King, 1982); (b) severity of the drinking and marital problems targeted by the couples therapy project; and (c) previous help-seeking and motivation to improve the marriage.

Ten demographic variables were: living distance from clinic; years married; number of children; age, education, and income of each spouse; and husband's employment status (1 = employed full-time, 0 = not employed full-time).

Three measures of husband's drinking severity were total years problem drinking, number of alcohol related hospitalizations, and number of alcohol-related arrests. Five marital relationship measures included number of separations, and each spouse's marital adjustment (Marital Adjustment Test (MAT); Locke & Wallace, 1959) and marital stability (Marital Status Inventory (MSI); Weiss & Cerreto, 1980). High scores on MAT indicate more favorable marital adjustment, and high scores on MSI indicate greater current potential for separation and divorce.

The final three measures were amount of help seeking for the husband's drinking in the previous year (Alcoholics Anonymous, outpatient treatment, marriage counseling, Antabuse) and motivation of each spouse to improve the marriage (self-rating on a 1-9 scale from "not motivated" to "extremely motivated").

Results

A stepwise multiple discriminant analysis was used for comparing scores of acceptors and rejectors. Because scores on 23 variables were available for analysis, and because husbands' and wives' scores were not independent, variables were entered into the discriminant analysis in four priority groupings. Variables within each group were entered in a stepwise manner using Wilks' method and $F = 1$ as an inclusion criterion. Our major goal was to maximize the applicability of the present results to other clinical settings many of which do not routinely contact alcoholics' spouses or conduct a multifaceted marital evaluation. Therefore, easily obtainable measures were given selection priority over measures requiring more cost and effort. Group 1 included five demographic variables: distance from clinic (miles), and husband's age, education, income, and employment status. Group 2 included three measures of husband's drinking severity and number of marital separations. Group 3 included husband's MAT and MSI, husband's help-seeking, and husband's motivation to improve the marriage. Group 4 included wife's income, wife's MAT and MSI, and wife's motivation to improve the marriage. Wife's education, number of years married, and number of children were significantly correlated with other variables and were not included in the discriminant analysis.

Insert Table 2 about here.

The discriminant analysis incorporated 11 variables for defining a significant discriminant function with Wilks' lambda = .612, X^2 (11) = 27.2, $p < .004$. Correct classifications were made for 27/35 (77.1%) acceptors and 23/28 (82.1%)

rejectors. Table 2 displays discriminant function coefficients and means and standard deviations for acceptors and rejectors for the eleven measures contributing significant variance to the discriminant function. Acceptors, when compared to rejectors, were characterized by husbands with more years of education, better marital adjustment, full-time employment, and more alcohol-related arrests. Acceptors also had engaged in more outpatient help-seeking in the past year, admitted drinking had been a problem for a greater number of years, and had experienced more marital separations. Rejectors were characterized by wives with better marital adjustment, greater living distance from clinic, and husbands with more alcohol-related hospitalizations. Rejector husbands also tended to be older.

Discussion

The present results have practical implications (a) for planning outreach and marketing efforts to attract alcoholics likely to accept marital therapy and (b) for identifying and dealing with potential rejectors of marital therapy among patients already seeking help in a given alcoholism treatment program. We will consider the implications for these two purposes of each of the three types of variables that discriminated acceptors from rejectors in the present study.

Researchers attempting to predict patient completion of or attrition from alcoholism treatment have advised that although patients' psychological characteristics may be important, situational factors and demographics should not be overlooked (Baekeland & Lundwall, 1975; Hahn & King, 1982). We arrived at a similar conclusion for predicting alcoholic couples' willingness to enter marital therapy. On the basis of the present results, marketing and outreach efforts should be targeted to alcoholics who have at least a high school education, currently are employed full-time, live within 10 to 12 miles of where the marital therapy will be provided, and are in their early 40's or younger. Certain strategies might be helpful for dealing with potential rejectors. The unemployed alcoholic should be provided with job-finding assistance (e.g., Azrin, 1976) before intensive marital therapy is started. For couples who live some distance from the clinic, a number of alternatives could be helpful including assisting potential rejectors with transportation, providing marital therapy services in the couples' homes or in decentralized satellite clinics nearer to patient's homes, or referring them to other more accessible treatment programs. Finally, older and less educated alcoholics might be less likely to reject marital therapy if pretherapy training (e.g., Craigie & Ross, 1980) was used to prepare them. In

addition, assessment and therapy procedures could be modified to reduce barriers to acceptance. For example, the use of questionnaires, particularly those with greater reading difficulty (Deutch et al., 1980), could be reduced to a minimum.

Factors relating to the husbands' alcoholism problem also affected couples' decisions to accept or reject an offer of outpatient marital therapy. Rejectors had experienced more alcohol-related hospitalizations, while acceptors had participated in more sources of outpatient help for alcoholism in the previous year. On the basis of these results we wondered whether the rejectors had more severe alcohol problems than the acceptors. Supplementary data analyses indicated that alcoholics in the two groups did not differ on Michigan Alcoholism Screening Test scores (Selzer, 1971), number and severity of withdrawal symptoms, number of jobs lost due to drinking, extent of liver problems, loss of driver's license, or on reports by alcoholics and wives about number of days in the previous year the alcoholics had spent drinking, hospitalized or jailed. These additional findings indicate that alcoholism severity, per se, was not the key difference between the groups and led us to speculate that the most important difference was the type of help sought for the alcohol problem. Rejectors had sought hospitalization, often for detoxification, a type of treatment in which the patient is a passive recipient of a brief period of medical help to relieve acute distress from drinking. Acceptors, on the other hand, had sought more help during the past year (AA, outpatient therapy, marriage counseling, Antabuse) that required active ongoing involvement oriented to prevention of relapse and improvement of overall quality of life. Seen in this light, it is not surprising that the acceptors were more receptive to marital therapy.

The different patterns of prior help seeking by acceptors and rejectors suggest that outreach efforts might be directed profitably to the AA network,

other outpatient alcoholism programs that do not provide marital therapy, and psychotherapists and marriage counselors who may have alcoholics whose drinking is not improving. Although detoxification centers and hospitals are a frequent source of referrals for outpatient marital therapy alcoholism programs, patients referred from such sources should be carefully screened to determine whether they have had a considerable number of prior hospitalizations. Such cases, especially when they show little evidence of other recent active help-seeking, may require considerable pretherapy training designed to help the alcoholic develop an active, ongoing, self-motivated approach to his alcoholism problem before marital therapy is an appropriate modality of treatment. Alternatively, the initial marital therapy contacts could be directed to identifying and resolving situational crises (e.g., financial and legal problems) that create hardship for the spouse and family with the hope that such concrete aid might make the couple more receptive to pretherapy training.

It is not surprising that marital factors, especially for wives, predicted acceptance of marital therapy. It is noteworthy that acceptor wives had poorer marital adjustment than rejector wives. Conversely, husbands' marital adjustment was better in the acceptors than the rejectors. Related research shows that such a discrepancy between spouses' reports of marital adjustment (with wives reporting more unhappiness) tends to be greater for male alcoholics and their wives than for female alcoholics and their husbands or maritally conflicted couples without an alcohol problem (Noel & McCrady, 1982; O'Farrell & Birchler, 1985). Other findings from the present study also suggest that wives may be an important force in bringing their alcoholic husbands to marital therapy, especially when they are unhappy with their marriage and motivated to do something about it. Inspection of the data on arrests, which were greater in the acceptor couples,

showed most arrests were due to drunken driving or alcohol-related domestic violence -- events that have a negative impact on the wife and tend to contribute to her marital unhappiness and increase the likelihood of her separating from the alcoholic (O'Farrell et al., 1981a). The acceptors' higher number of previous marital separations, most likely initiated by the wife (O'Farrell et al., 1981b), may indicate motivation to take action and make changes in one's life.

The wife's importance in a couple's decision to enter marital therapy argues strongly for targeting outreach efforts directly to wives who are experiencing marital and emotional distress as a result of their husbands' alcoholism. Advertising, press releases, and other media activities can be directed to wives. For example, our advertising for a new marital therapy project, which used the headline "Is alcoholism hurting your marriage?," was placed adjacent to the "Dear Abby" personal advice column on the day of each week of peak female readership. Outreach to potential referral sources could include Al-Anon members, marriage counselors and psychotherapists, clergy, divorce lawyers, domestic relations court and probation officers, hospital emergency rooms, pediatricians, gynecologists, and primary care physicians. Posters and brochures could be placed in women's hairdressers and beauty shops, grocery and convenience stores, laudromats and welfare offices.

Another implication of the results showing the wives' importance is that alcoholism programs desiring to use marital therapy should routinely contact and interview the alcoholics' wives in order to identify women who may want such treatment. Although this suggestion may seem rather obvious, currently many treatment programs do not do this but rather wait for the alcoholic husband to request marital therapy (Regan et al., 1983). The present results suggest this may not be the best approach.

In closing, it should be noted that this is the first systematic study comparing alcoholic couples who accept with those who reject marital therapy. Thus, measures contributing significant variance to the discriminant function in this study must be cross-validated in future studies. More specifically, the alcoholics in the present study were all from a VA population and a different patient population might yield different results. Additional studies also are needed to describe and evaluate effective methods for recruiting alcoholics and spouses into marital therapy programs and for motivating likely rejectors to continue in marital treatment once started.

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Footnotes

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Table 1

Descriptive Characteristics for 63 Alcoholic Husbands

Characteristic	Mean	Standard Deviation	Range
Age	43.9	9.6	24-64
Years of Education	12.1	2.3	7-17
Years Married	16.1	10.7	1-39
Previous Alcohol-Related Arrests	2.9	5.1	0-28
Previous Alcohol-Related Hospitalizations	4.2	7.2	0-48
Years Drinking a Problem	12.9	8.9	0-45
Michigan Alcoholism Screening Test Score[a]	39.0	7.9	19-53

[a]All scores are well above seven, a conservative indication of alcoholism (Selzer, 1971).

Table 2

Discriminant Analysis Comparing Acceptors and Rejectors

Measure[a]	Discriminant Coefficient[b]	Acceptors M	Acceptors (SD)	Rejectors M	Rejectors (SD)
Education H	.723	12.5	(2.3)	11.9	(2.3)
Marital adjustment H	.494	88.8	(24.4)	86.6	(36.2)
Full-time employment H	.458	.8	(.4)	.5	(.5)
Marital adjustment W	-.432	72.8	(32.6)	81.6	(35.6)
Alcohol-related arrests	.414	3.4	(6.3)	2.7	(3.9)
Distance from clinic	-.365	11.9	(9.1)	17.4	(12.6)
Alcohol-related hospitalizations	-.355	2.1	(1.6)	6.2	(9.2)
Age H	-.300	42.2	(9.3)	46.9	(9.3)
Help-seeking past year	.300	2.4	(1.2)	1.6	(1.3)
Years problem drinking	.290	13.8	(9.9)	12.3	(7.5)
Separations	.115	2.0	(2.1)	1.0	(1.4)

[a]H = husband. W = wife.

[b]These are standardized discriminant function coefficients. Measures with positive discriminant function coefficients are most descriptive of acceptors. Measures with negative coefficients are most descriptive of rejectors (Tatsuoka, 1970).